PA PSRS
Pennsylvania Patient Safety Reporting System

Patient Safety Advisory

Produced by ECRI & ISMP under contract to the Pennsylvania Patient Safety Authority

Changing the Culture of Seclusion and Restraint

The Commonwealth of Pennsylvania demonstrated leadership in behavioral health when the state hospitals participated in an aggressive statewide program to significantly reduce the use of seclusion and restraints. According to Steven Karp, DO, former Chief Psychiatric Officer of the PA Department of Public Welfare, seclusion hours:

> "…dropped from more than 5,000 in February 1993 to just over 4 in February 2003. During this same period, the number of mechanical restraint hours dropped from almost 11,000 to slightly more than 90. Two state hospitals in Pennsylvania have not used restraints, and two others have not used seclusion, in more than two years."[1]

Further, staff injuries did not increase during this period as a result of decreased use of seclusion and restraints.[2]

The clinical literature on mental health treatment frequently refers to this statewide success story as evidence that a safe environment can be attained for psychiatric patients without resorting to force. Restraints and seclusion became the exception rather than the rule in response to patient's escalating behaviors. The state hospitals' change in delivery of care was an extraordinary accomplishment which was acknowledged in October 2000, when Pennsylvania's Seclusion and Restraint Reduction Initiative received the prestigious Harvard University Innovations in American Government Award."[2]

As the state hospitals met the challenge of providing support rather than control over the institutionalized mentally ill, a newspaper in Connecticut was reviewing deaths related to the use of seclusion and restraints in the nation. The investigative reporting of the *Hartford Courant* in October 1998 was precipitated by the death of a restrained 11-year-old. The article documented 142 deaths related to restraints nationwide over a decade.[3] The leading cause of death related to restraints was death secondary to unintentional asphyxiation that occurs during the restraining of the patient. The very act of restraining brings significant risk to the patient and staff, and today restraints are recognized as an extreme use of force. According to one researcher, "high restraint rates are now understood as evidence of treatment failure."[4]

With the national focus on the behavioral health industry, both regulatory and accrediting bodies took on the mission of changing their standards to address the goal of reducing seclusion and restraint use. Healthcare providers have changed not just policies and procedures but also their philosophical model for managing the combative patient. This model has shifted from control to collaboration, from force to facilitation, and from dominance to empowerment. Patient injuries associated with seclusion and restraint were the catalyst for an opportunity to explore alternatives in care delivery for this patient population.

> *Healthcare providers have changed their philosophical model for managing the combative patient from one of control to one of collaboration, from force to facilitation.*

Regulatory and Accrediting Obligations

The Centers for Medicare and Medicaid Services have revised the conditions of participation such that patients have the right to "freedom from restraint and seclusion use to manage violent or aggressive behavior unless clinically necessary."[5] OSHA has provided Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers[6] and "has cited healthcare facilities under its general duty clause for failure to prevent patient violence against healthcare workers since at least 1993."[7]

Accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have stringent standards on restraint use that are applied everywhere in the acute care setting where behavioral patients are managed, including the Emergency Department, medical/surgical units, and oth-

This article is reprinted from the *PA-PSRS Patient Safety Advisory*, Vol. 2, No. 1—March 2005. The Advisory is a publication of the Pennsylvania Patient Safety Authority, produced by ECRI & ISMP under contract to the Authority as part of the Pennsylvania Patient Safety Reporting System (PA-PSRS).

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ers.[8] The Proposed 2006 National Patient Safety Goals and Requirements and Rationale Statements for Behavioral Health Programs includes reducing "the risk of harm associated with emotional and behavioral crisis."[9] These draft standards reinforce JCAHO's commitment and focus on the issue of forceful patient management.

Current Knowledge on Seclusion and Restraints
What do we know of the effectiveness and therapeutic value of restraints and seclusion? A 2003 literature review on the use of physical restraints and seclusion came to the following conclusions:

- Seclusion and restraints are used frequently, but the actual rate is unknown.
- Least restrictive alternatives are considered effective, though this has not been empirically studied.
- Educational programs have been effective in reducing the use of seclusion and restraints.
- Legal and ethical issues will continue until research demonstrates the efficacy of seclusion and restraints.
- Until empirical research supports a change, there is consensus that the least restrictive measures are preferable.
- Restraints could be used "less arbitrarily, less frequently, and with less trauma" than in current practice.
- Staff education is an effective tool in reducing the incidence of restraint and seclusion.
- Research is critical to address the many issues related to predictive behaviors, effectiveness, alternatives, legal and ethical ramifications.[10]

Organizational Responses to Minimizing Restraint and Seclusion Utilization
How can a multidisciplinary team respond to an escalating patient situation without resorting to force? Some clinical teams have changed the way they think about the needs of the patient and have moved toward a more humanistic approach of supportive negotiation rather than control. The successful change to less restrictive behavior management necessitates more than procedural changes but rather a philosophical and cultural change to the point where the patient is encouraged and supported as a participant in their treatment plan. "Values of respect and dignity must permeate the system, and disrespectful behavior by staff must be confronted and changed."[11]

Strong leadership with management and staff accountability is essential. The physician's role as clinical leader is critical in moving the multidisciplinary team toward a change in response to the patient with escalating behavior. *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/ Seclusion in Behavioral Health*[12] was published collaboratively by the American Psychiatric Association, the American Psychiatric Nurses Association, and the National Association of Psychiatric Health Systems. This online resource offers creative approaches to providing an environment of caring rather than one of control.

For example:

- Building a sensitive program by putting yourself in the patient's place.
- Having patient-centered policies as the infrastructure of the program.
- Proactively negotiating with patients for their suggested alternatives to crisis management.
- Identifying alternative management strategies with your peers in collaborative workgroups.
- Rooting out the underlying causes of aggressive behavior.[12]

Communication is central when shifting the treatment model from one of force to one of support. Organizational and clinical leaders are encouraged to be in "constant dialogue with staff"[12] and to consistently reinforce the reframing of care such that "least restrictive" becomes "most facilitative." The language and labels used in the clinical setting are important. Consider proactive prevention, by shifting from a show of force to a show of support. In this alternative environment, isolation for patient management shifts towards an upbeat and supportive setting such as a "comfort room" rather than the punitive-sounding "time out room."[13]

Education is key to assure that staff at the front line are skilled in de-escalating techniques and are prompt in responding to defuse potentially volatile situations. Almost every article includes emphasis on staff education.[14,15]

Some additional considerations:

- Reading and reviewing policies according to a schedule.
- Developing a competency based education for interdisciplinary staff.

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- Requiring staff to demonstrate their competence on an ongoing basis.
- Using role playing to reinforce de-escalation interventions.
- Delivering education conveniently around-the-clock.
- Holding staff accountable for their education.[12]
- Educating patients on the changes occurring.[15]
- In programs that manage children and adolescents, training in developmentally appropriate strategies for carrying out seclusion and physical and chemical restraint, including hands-on practice with restraint equipment and techniques and cardiopulmonary resuscitation (CPR) training.[16]
- Incorporating cultural changes into the educational program requires integrating shared values of dignity and respect while minimizing the need for controlling measures which are reserved for the most extreme situations.[11]

Team Development and Deployment

CPR is called by a code name in most institutions to provide discretion in a sensitive situation and to notify the team of clinical specialists skilled at resuscitative measures as to where to respond. Each member of the team has a specific responsibility. These team members do two things. First, they provide an advanced level of knowledge and skill to a life-threatening situation. Second, they provide supplemental staff to support the needs of a patient in crisis, thus allowing the staff to attend to the needs of the other patients.

Similarly, the behavioral health code involves pre-identified staff responding to the request for support in managing a patient with challenging behavior. The behavioral team members are equally highly skilled

Reports Involving Seclusion and Restraint Submitted to PA-PSRS

Since its inception, PA-PSRS has received multiple reports describing restraint or seclusion of behavioral health patients. Typically these reports do not include the particulars of the efforts to manage the situation, but they do highlight what occurred when a patient's behavior cannot be contained. Occasionally, reports describe staff interventions. For example:

- Escalating behavior requiring four staff to escort the patient to seclusion, administration of intramuscular medications and two hours later patient returned to the patient's room to sleep.
- Peer to peer aggression, response team called to intervene, time out initiated, no injuries noted.
- Patient attempting to inflict harm to self, staff intervened, no harm occurred to patient.
- Crisis team and police called. Patient was holding another patient. Pepper spray was used to subdue the patient.

When a patient demonstrates escalating behavior the clinical team responds in an individualized, strategic, progressive manner. The efforts generated are to contain the situation yet remain supportive of the patient in crisis. When de-escalating techniques fail, the risk versus benefit of restraining is considered, and ultimately the situation may necessitate restraint to protect the patient or others. In these frustrating and disturbing situations the potential for injury—even death—exists. PA-PSRS has received reports of patient injuries which have occurred during restraining, most of which are lacerations, abrasions, and bruises. However, there are seven cases in which the patient sustained a fracture, and one of these cases required surgery. The demographics of the affected patients are revealing in that six of the seven patients are male, with ages ranging from 12 to 56.

One detailed report provides some insight into the extent of clinicians' efforts to manage a challenging situation:

> The patient was asked to take a time out due to verbally threatening behavior during a group session. Attempts to redirect were unsuccessful. While in time out, the patient began to push staff. He was placed in a manual hold and continued to be combative. He was placed in mechanical restraints until calm. The next day he complained of right shoulder discomfort. An x-ray indicated a fracture of the greater tuberosity of the humerus, which was later confirmed by the orthopedist.

This case exemplifies multiple, gradually escalating levels of intervention: time out, redirection of patient behavior, and manual hold necessitating the use of force. Finally, restraints were applied as a last resort.

In this case the hold used was not described beyond a "manual hold," but holds have been associated with injuries even fatalities.[1,2] Certain holds (such as the chokehold or the basket hold) and positions (face down/prone) are particularly threatening to the patient, and many organizations have banned their use.[3] Restrictive measures applied to the neck or near the patient's airway are particularly hazardous. Compression of the chest also carries the risk of positional asphyxiation if the chest's normal respiratory expansion cannot occur.

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Reports Involving Seclusion and Restraint Submitted to PA-PSRS (Continued)

The JCAHO Sentinel Event Alert on Preventing Restraint Deaths[4] reports that 30 percent of restraint-related deaths occurred during a therapeutic hold. When absolutely necessary and all other less restrictive measures have failed in managing a situation where the patient, other patients, and staff are threatened, restraining of an individual may be necessary. Certain factors or patient characteristics may place the patient at greater risk of fatality during restraint, such as:

- Neck holds
- Obstruction of nose, mouth, or chest expansion
- Prone or hobble tying
- Hyperflexion in a seated position
- Obesity
- Heart disease
- General poor health
- Exhaustion or prolonged struggling
- Illicit or prescribed medications
- Drug intoxication[1,2,5]

Recognizing the hazards of patient restraint, consider the following strategies to mitigate the risk:

- Redoubling efforts to reduce the use of physical restraint and therapeutic hold through the use of routine risk assessment and early intervention with less restrictive measures.
- Enhancing staff orientation/education with alternatives to physical restraints and proper application of restraints or therapeutic holding.
- Developing structured procedures for consistent application of restraints.
- Continuously observing any patient in restraints.
- If a patient must be restrained in the supine position, ensuring that the head is free to rotate to the side and, when possible, elevating the head of the bed to minimize the risk of aspiration.
- If a patient must be restrained in the prone position, ensuring that the airway is unobstructed at all times (for example, not covering or "burying" the patient's face).
- Ensuring that expansion of the patient's lungs is not restricted by excessive pressure on the patient's back (with special caution for children, elderly patients, and obese patients).[4]

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and typically have certain physical characteristics of size and strength. More important than their size and strength is their commitment and competence in delivering a clinical intervention that supports the patient in a non-threatening manner.

These rapid response teams have been mentioned in some PA-PSRS reports. Two widely used terms are "Code Gray" for combative individuals and "Code Silver" if a weapon is brandished.[7] Pennsylvania state hospitals use the acronym "PERT," Psychiatric Emergency Response Team, according to Dr. Karp.[17]

Behavioral health code teams provide advanced skills at negotiating, verbal de-escalation techniques, and safe methods of containing a struggling patient. Remaining supportive rather than controlling is the goal, but despite the best of efforts, some situations may need to be managed with force. It is important to remember that restraining the already traumatized psychiatric patient can have long lasting physical and emotional consequences.

Debriefing or Restraint Review

When it is necessary to use force and restrain a patient, an opportunity for improvement exists. How could this situation been handled differently? Did the patient provide clues to their changing needs? Were the interventions attempted sufficient? Could a compromise been employed? If we had intervened earlier, could the situation have been managed with a less restrictive intervention?

Reviewing interventions immediately after occurrence in a "debriefing" format allows the clinical team to confront the successes and shortcomings of the team response, the interventions, and alternatives attempted. Aside from dissecting the event, consideration of the attitudes and feelings of the staff, the victim, and those patients who witnessed the event are of value. A patient-centered program is sensitive to the perceptions of all involved in an effort to understand individual responses. Ultimately these internal reviews are intended to improve the response to future events.[7,12,15]

Changing the Culture of Seclusion and Restraint (Continued)

While Pennsylvania has assumed a leading role in reducing restraint and seclusion use, there is still room for improvement. Additional effort is necessary to reduce the need to resort to restraint and seclusion and, when restraint becomes necessary, to minimize the risk of patient injury. Though restraining the patient is recognized as "a treatment failure"[4] it is acknowledged that in some situations restraints are vital in preventing injury to patients and/or staff.

Notes

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An Independent Agency of the Commonwealth of Pennsylvania

The Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act. Consistent with Act 13, ECRI, as contractor for the PA-PSRS program, is issuing this newsletter to advise medical facilities of immediate changes that can be instituted to reduce serious events and incidents. For more information about the PA-PSRS program or the Patient Safety Authority, see the Authority's website at www.psa.state.pa.us.

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